Disclosure of Sexual Preference to Physicians by Black Lesbian and Bisexual Women

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Physicians' ability to diagnose and treat health care problems, particularly those with a psychosocial component, is facilitated by accurate information concerning the life-styles of their patients. White lesbians have been shown to be generally reluctant to disclose sexual orientation to their physicians, but little, if anything, is known about black lesbians. Black women, self-identified as bisexuals (N = 65) and lesbians (N = 529), were asked whether they had disclosed their homosexual behavior to their physicians. In the sample, only a third of the women had. Previous sexual experiences, both heterosexual and homosexual, were also queried to illuminate patterns of gynecologic health risk factors. Nearly all of the women reported previous heterosexual experiences.

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While medicine in recent years has paid increasing attention to the medical concerns of American white gay men,[1] less attention has been focused on the health issues of bisexual and lesbian women.[2] Patterns of health problems in the white lesbian population include rates of sexually transmitted diseases in general,[3] *Chlamydia* and resulting pelvic inflammatory disease,[4] menstrual irregularities,[5] and possibly cervical dysplasia, that are lower than those in white heterosexual women, although the evidence for this for cervical dysplasia is contradictory.[3,4] The existence of specific patterns of vaginitis transmission has been suggested,[2] as well as possibly higher rates of alcoholism[6] and perhaps specific problems such as endometriosis and breast cancer.[3]

Extrapolating these findings to the black lesbian population is problematic. Little is known specifically about the lives of black lesbians (V. M. M., "The Impact of Perceived Discrimination on Black Women's Relationships," unpublished data, October 1985). An early study reports that black lesbians have had more extensive heterosexual experiences than white lesbians.[7] In a second study, black lesbians rated themselves on the Kinsey scale as less exclusively homosexual in their sexual behaviors than their white lesbian counterparts, though they were no more likely to have experienced coitus ever or in the previous year.[8] They also reported higher rates of prior heterosexual marriage and were more likely to have had children. This suggests that black lesbian women may be more heterosexually active both in the past and currently than white lesbians. Heterosexual behaviors may conceivably predispose them to a different pattern of gynecologic problems than those reported by white lesbians.

While the sexual orientation of a patient is not always relevant to adequate health care, women are more likely than men to seek medical care for preventive health purposes, especially for diseases of the genitourinary system, for family planning, and for psychosocial reasons.[9] Knowledge of a woman's psychosocial environment, including her sexual history and current sexual behavior, may aid a physician in considering diagnoses that may not be initially entertained and to discard others that are inappropriate. This is particularly true for sexually transmitted diseases. Yet, studies of predominantly white lesbians and gay men indicate that only somewhere between 18% and 49% disclose their sexual orientation to their physician.[3,10,11]

We examine the disclosure of sexual orientation by black lesbian and bisexual women to their physicians. It has been shown among predominantly white women that bisexual women are less likely to disclose than are lesbians.[10] We were interested in whether or not this would also be the case for black lesbian and bisexual women. In addition, we also sought to document both homosexual and heterosexual experiences of a large sample of black lesbian and bisexual women to begin to clarify possible health risks. Elsewhere it has been suggested that screening for sexually transmitted diseases may not be cost-effective with lesbians.[4,6] To the extent that black lesbians are involved in active heterosexual behaviors, however, this advice would be unwarranted.

Methods

Recruiting Participants

Participants were recruited for a study of black lesbians' relationships in several ways. Several black gay organizations, including the National Coalition of Black Lesbians and Gays and local Los Angeles groups, mailed to their female members copies of our questionnaire to complete and return in prestamped envelopes. A postcard included with the questionnaire but returned by mail separately to preserve the anonymity of respondents gave participants an opportunity to request additional questionnaires for friends. In addition, information about the survey was distributed nationally by flyers to lesbian bars listed in publications of the homosexual

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ABBREVIATIONS USED IN TEXT
AIDS = acquired immunodeficiency syndrome
HIV = human immunodeficiency virus

community and by press releases to gay newspapers. Possible participants were asked to call a listed telephone number if they desired a copy of the questionnaire. Packets of questionnaires were also mailed to businesses nationally, such as bars and bookstores, that cater to a lesbian clientele. About 2,100 questionnaires were distributed in this manner, and 607 women returned completed questionnaires. Of the responses, 13 were excluded for the following reasons: an absence of lesbian sexual experience (two women), self-identified as heterosexual (three), not of Afro-American ethnic minority background (six), and largely incomplete questionnaires (two).

Participants

Questionnaires were completed by 529 lesbians and 65 bisexual women. All participants were black women who reported at least one previous sexual experience with a woman and who were self-identified as either a lesbian or a bisexual woman.

Demographic characteristics of the sample are shown in Table 1. In general, the two samples were similar. The average participant was in her early 30s, well-educated, and from a middle-class background. About two thirds of both samples had never been married and a third reported having had at least one child. Lesbians were no less likely to have had a child or to have been heterosexually married than bisexual women.

TABLE 1.—*Demographic Characteristics of Participants*

Characteristics	Lesbians, N=529	Bisexual Women, N=65
Mean age, years	33.5±7.7*	31.7±7.8*
Mean socioeconomic background†	3.0±0.8	3.1±0.8
Mean years of schooling completed	15.4±2.6	15.2 ±2.6
Annual income, %		
Less than $5,000	8	11
$ 5,000 to $10,999	17	20
$11,000 to $19,999	35	31
$20,000 or more	40	38
Marital status, %		
Never married	67	61
Formerly married	31	34
Currently married	2	5
Percentage with children	34	39
Geographic region, %		
West, Northwest, or Southwest	50	50
Northeast or East	22	27
Midwest	14	9
South or Southeast	14	14

*± standard deviation. Lesbian and bisexual participants do not differ significantly.
†A score of 3.0 is equivalent to a middle-class background.

TABLE 2.—*Disclosure of Sexual Preferences to Physician*

Disclosure Answers	Lesbians, N=529	Bisexual Women, N=65	
Does not have a personal physician, %	16	13	
Has a personal physician, %	84	87	
For those with personal physician			
Physician does not know, %	45	66	*
Physician may suspect, %	11	7	
Physician knows but topic not actually discussed, %	11	9	
Physician knows and topic has been discussed, %	33	18	

*P < .05.

Questionnaire

The 27-page questionnaire covered several topics relevant to women's relationships with love partners, friends, family, and the larger social world. These included disclosure of sexual orientation and previous sexual experiences with both men and women, among other topics. Questions were adapted from an earlier study by one of us (V.M.M.) of black lesbians and studies of white lesbians,[13,14] white gay men,[15] and white heterosexual college students.[16] The questionnaire took about an hour to complete and was self-administered.

Results

Disclosure of Sexual Orientation

Lesbians and bisexuals did not differ in reporting having a personal physician; more than 80% in both groups did. Among those with physicians, however, many assumed that their physicians did not know the participant's sexual orientation (Table 2). For lesbians, about a third (N = 142) had openly talked about their orientation status with their physicians. Another 11% (46) assumed that their physicians knew but said they had not discussed the topic. Bisexual women were significantly less likely than lesbians to have disclosed their same-sex sexual behavior to their physicians (χ^2 [3] = 8.59, $P < .05$). About 18% (10) had talked with their physicians, while another 10% (5) assumed that their physicians knew.

Sexual Experiences

There was a trend for lesbians to report a higher median number of female sexual partners by history than there was for bisexual women (Mann-Whitney $U = 14{,}035$, $P < .06$; Table 3). In addition, lesbians were less likely than bisexual women to report having had heterosexual coitus (χ^2 [1] = 4.36, $P < .05$), though both samples generally reported that they had. As might be expected, bisexual women reported having had significantly more male sexual partners (Mann-Whitney $U = 9{,}961$, $P < .001$) and more recent hetero-

TABLE 3.—*Patterns of Sexual Experiences*

Sexual Experience	Lesbians, N=529	Bisexual Women, N=65	
Female sexual partners, median No.	9	7	
Heterosexual experiences			
Has had sexual intercourse, %	90	99*	
Male sexual partners, median No.	5	8†	
Last previous heterosexual experience, median mo	67	7†	
Had coitus in previous year, %	12	65†	
Currently heterosexually active, %			
Never	88	44	†
Rarely	10	36	
Sometimes	2	12	
Regularly	1	8	

*P < .05.
†P < .001.

sexual involvement both in months since last heterosexual activity (Mann-Whitney $U = 4,275$, $P < .001$) and within the previous 12 months (χ^2 [1] = 83.0, $P < .001$). Also, bisexual women reported a higher current rate of heterosexual involvement, with 56% (36) reporting that they were heterosexually active at least "rarely" (χ^2 [3] = 90.1, $P < .001$).

Sexual orientation labels, however, are not always illuminating. As can be seen, within the lesbian sample, 13% of women (63) reported that they were currently heterosexually active at least "rarely" and 12% (58) reported having had coitus within the previous year. Among bisexual women, 44% (28) reported that they were "never" sexually active with men and 35% (22) indicated no coitus in the previous year.

Discussion

With the increasing concern about sexually transmitted diseases, it becomes even more important to understand individual patterns of sexual behavior. This is facilitated by both a knowledge of what is normative for similar persons and frank disclosure by patients. The present study provides important information about the behavior of black lesbian and bisexual women. As with earlier studies of black lesbians,[7,8] respondents in this survey showed extensive previous heterosexual experience. Nearly 90% of the lesbians (472) and virtually all of the bisexuals (64) had had heterosexual coitus. This is similar to the 88% rate reported by Bell and Weinberg for black lesbians in their study.[8] In contrast, research has shown that 80% to 83% of white lesbians have had heterosexual coitus.[7,8,13] While the black lesbians in the present study were less likely to be heterosexually active in the previous 12 months (12%) than black lesbians in the Bell and Weinberg study (33%), our participants were somewhat older and so may have been experimenting less with their sexual behavior in general.

The overall consistency of these findings suggests that black lesbians may, in fact, as a group have more extensive heterosexual experience than white lesbians, although such a conclusion should be viewed as tentative because a direct comparison of similar samples is unavailable. The prevalence of previous heterosexual experience among black lesbians suggests that diagnostic considerations relevant to sexually transmitted diseases, such as *Chlamydia,* should be entertained when treating black lesbian patients. Also, although lesbians are presently at extremely low risk for infection with the human immunodeficiency virus (HIV) responsible for the acquired immunodeficiency syndrome (AIDS),[17] given the higher prevalence rate of AIDS within the black community in general[18] and the possibility that when lesbians are heterosexually active it occurs more often with gay and bisexual men,[19] there may be a need for preventive health education efforts specifically targeted at black lesbians who are or have recently been heterosexually active.

Results reported here provide further evidence that lesbians and bisexual women are often reluctant to disclose their sexual orientation to personal physicians. In an earlier study of primarily white respondents, about 47% of lesbians and 30% of bisexuals had told a gynecologist of their sexual orientation.[10] In the current survey of black women, 33% of lesbians and 18% of bisexuals reported having discussed the topic with a physician. If we include the women who believed that their physicians knew of their sexual orientation but who had not actually discussed the matter, then 44% and 27% of black lesbians and bisexuals, respectively, believed that their physicians knew the respondents' sexual orientation. As shown in the earlier study, bisexual women were significantly less likely to disclose to physicians than were lesbians.[10] It seems that black lesbian and bisexual women share the reluctance seen among white lesbian and bisexual women to disclose their sexual orientation to physicians, although the precise reasons for this were beyond the scope of the present study. For black lesbians, problems with disclosure may be twofold. If they do not inform their physicians about their sexual orientation, they are likely, as with white lesbians, to experience health care that is alienating, if not inappropriate.[3,12] If they do disclose and physicians assume a pattern of health risk consistent with white lesbians, they may also receive inadequate care because physicians fail to distinguish differences in life-styles within the lesbian community.[1]

Several methodologic concerns should be kept in mind. First, the women who participated in this study may not be a representative sample of black lesbians and bisexuals. Representative sampling from a hidden population is not possible.[20] Thus, the study may overestimate the prevalence of openness about sexual preference with physicians because the women who returned the survey are more likely to be open about their sexual preference in general. Furthermore, our sample consisted predominantly of urban, educated, and upwardly mobile middle-class black lesbian and bisexual women who were predominantly from the West Coast. Their experiences with the health care system probably differ significantly from those of less educated, lower income black women who are restricted to the use of public health care facilities. This latter group may be less likely to have access to a regular physician with whom they feel comfortable disclosing their sexual preference. Further research is needed that surveys this segment of the black lesbian population.

Nevertheless, results indicate that physicians should not assume that all black women are sexually active only with male partners. As shown here, most black lesbian and bisexual women do not actually discuss their sexual orientation with physicians. A history of childbearing or a previous marriage is not always an indicator of current heterosexual status. Nearly a third of the lesbians in this study had given birth and a similar percentage either had been or were currently married. Nor should physicians assume that the disclosure of a lesbian orientation implies a lack of extensive previous heterosexual experience or current heterosexual involvement that may predispose to particular gynecologic problems, sexually transmitted disease, or HIV seropositivity resulting from heterosexual activity. Kinsey's data clearly show that sexual object choice may not always be an either/or preference.[21] In our overall sample of 594 black women, 91% had had heterosexual experiences, and, for many women, these experiences were extensive. Only the taking of comprehensive sexual histories can avoid problems of assuming exclusive heterosexual or homosexual involvement.

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Clinical Response to Inhaled Steroids

THE BIG ADVANCE, and I think our knowledge is still advancing a lot in how to use these preparations, has been in the development of topical preparations not associated with the systemic side effects of prednisone therapy. These are topical preparations that, when inhaled into the airways, are poorly absorbed, and what is absorbed is so rapidly metabolized that it has little effect on the adrenal pituitary axis. These do not cause the osteoporosis, particularly in postmenopausal women, or the premature cataracts—seen with much greater frequency than has been appreciated—that are associated with oral prednisone therapy for obstructive lung disease.

Davies studied 33 subjects treated with beclomethasone dipropionate (Vanceril) and found decreased daytime and nocturnal symptoms of asthma, decreased need for β-adrenergic aerosols and for prednisone, and an increased measure of forced expiratory flow. And here is the interesting phenomenon: for up to nine months, patients who were requiring prednisone were able to come off it.

Now we have been taught, I think by the pharmaceutical companies themselves, that one month is the therapeutic trial period for an inhaled steroid. I am going to differ with that. If a patient responds to oral prednisone, that patient merits an aggressive trial with an inhaled steroid, and at the end of four weeks, that patient has probably not achieved the maximum benefit that can be obtained from that drug. Some clinical response should be noted, but the maximum effect may not be seen for nine months. In other words, patients with mild, moderate, or even severe asthma, who may be discouraged about their condition after a month on an inhaled steroid, may still improve, and their prednisone requirements will be reduced over the next eight months—a reason for optimism.

—HOMER A. BOUSHEY, MD

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